MEDI ASSIST INDIA TPA PVT LTD

Investigation & Fraud Control Dept

FRAUD CONTROL CAPABILITIES

- **Medi Assist has an Investigation Process for detecting Fraud claims which is a part of the ISO - Quality Management System and an in-house Investigation team of 25 - 30 investigators consisting of doctors & para medics and empanelled investigation agencies across the country to investigate all suspected fraud claims.**

- **This Process spells-out on broad terms to identify & purge-out the potential cases for Investigation from all claims reported to us.**

- **Certain fraud prone categories of claims are mandatorily investigated apart from well defined triggers for need based investigations.**

- **Suspected Frauds are countered by our in-house medically qualified claims processing team who thoroughly analyze / scrutinize the data provided in the claims reported (PA & RI). Where-ever aberrations are noticed, such cases are referred to the Investigation department.**

- **This is followed by Investigator's visits / discussions with Hospitals/Claimants for correct inference before disposal / denial of the claims.**

- **Annual training workshops are conducted to all Investigators to motivate and improve qualitative and quantitative investigation targets.**

- **Induction programme and periodical workshops are conducted to all those who process claims on trigger points and identification of potential claims for investigation.**

- **PA tele call investigation: The Pre-Authorization requests are individually examined to pick-up potential cases for Investigation.**

- **Each and every PA of this category is followed-up through phone call to Hospital / Patient / their representatives to extract more information.**

- **The answers given are carefully analyzed for prima facie inference whether it requires more probe. There after Hospitals are visited for in-depth investigation to detect frauds / mis representations / suppression of material facts etc.**

- **We have IT supported Pop-Up alerts which draws the attention of claim processors to revisit the claim for thorough scrutiny and to push it to investigation where ever aberrations are noticed.**
- **Pop-Up alerts like Red Flagged Hospitals / Suspected Hospitals/ Potential cases for investigations are regularly reviewed and updated in the system.**

TRIGGER POINTS TO INITIATE INVESTIGATIONS

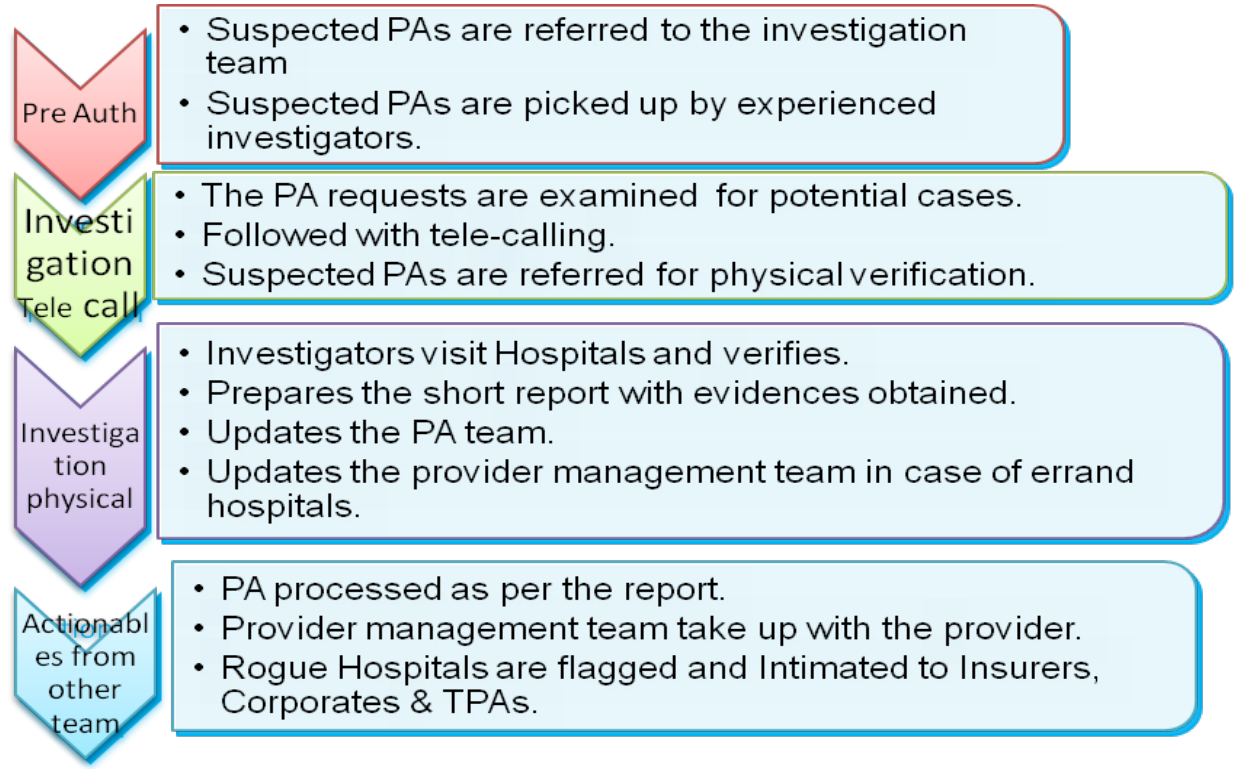
- **Claims from Red Flagged Hospitals.**
- **Claims from suspected Hospitals.**
- **High value RI claims from network hospitals.**
- **Close proximity claims.**
- **All RTA claims.**
- **All drug overdose claims.**
- **All suspected claims of excluded ailments like infertility treatment, Congenital external etc.**
- **All suspected claims of alcohol related ailments.**

- **All abortion claims.**
- **Repeated claims from same hospital for the same ailment from the same insured.**
- **All chronic ailment claims from standard policies.**
- **Claims with altered bills / documents without proper counter signatures.**
- **Claims with highly inflated bills in comparison to the treatment provided.**
- **Claims of suspected OP treatment converted as IP treatment.**
- **Claims of admissions documented for just 24 hrs.**
- **Claims with highly inflated pharmacy bills / bills in chronological order.**
- **Claims with highly inflated bills with unrelated diagnostic tests / investigations.**
- **Claims with colour photo copies.**
- **Claims for treatments in geographically far off hospitals from the insured's residential address.**
- **Claims with any other matter to be suspicious.**

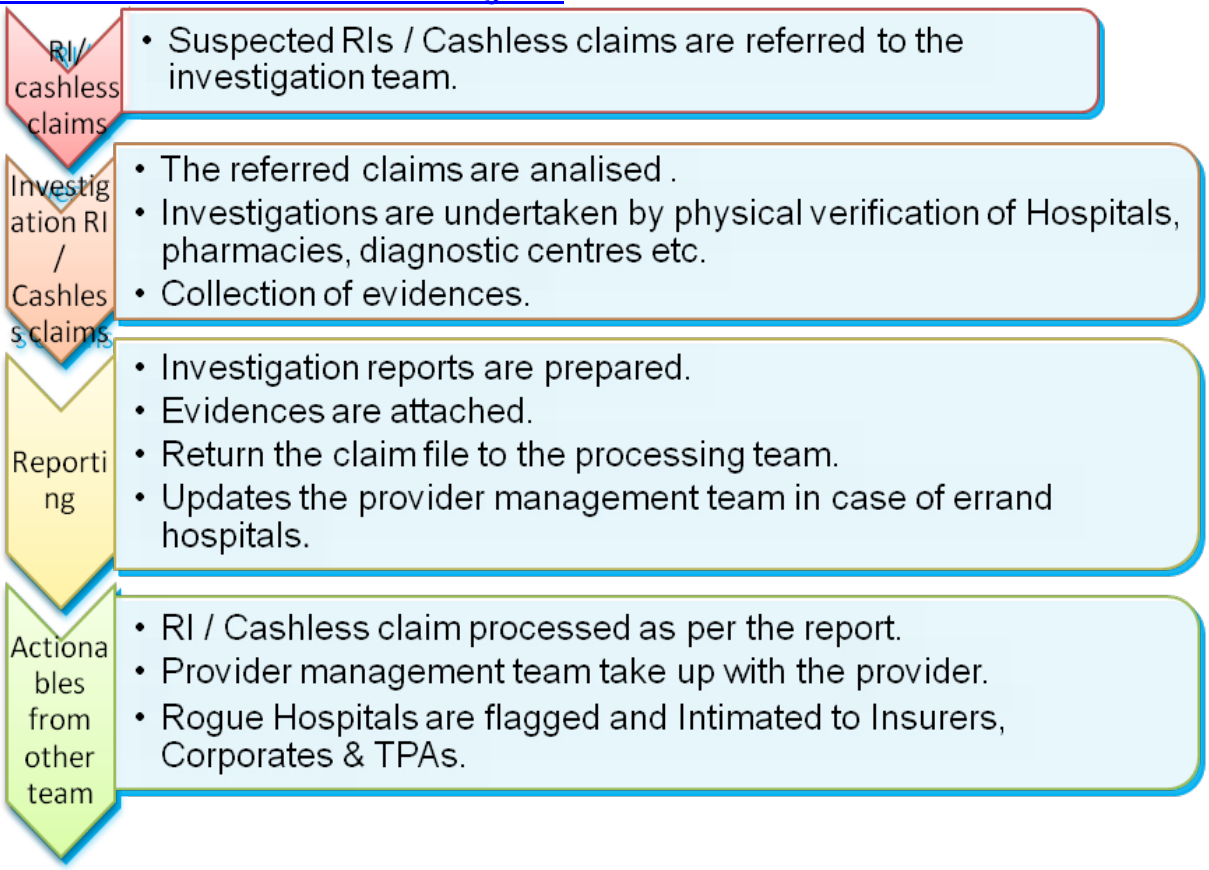
Types of common frauds

- **Fictitious admission.**
- **Pre existing disease.**
- **Inflated bill.**
- **Misrepresentation.**
- **Suppression of material facts.**
- **Conversion of excluded ailment to covered ailment.**
- **Conversion of OPD treatment to IPD.**
- **Alteration of documents.**

Process for Pre Authorisation investigation



Process for RI / Cashless claim investigation



Case studies

Case Study No.1

Name of the Hospital : "X" Hospital, Bangalore
Type of policy : 18 Individual Policies.
Claim Type : Reimbursement.
Claim amount : Approx. 5 lacs.
Type of fraud : Fictitious Admissions

Investigation Findings: This hospital had generated admission documents and claimed in the name of non-existing insured. On thorough scrutiny of the documents by our experts, it was observed that a stereo type pattern is followed in all these claim documents.

A team comprising of doctors, expert investigators of Medi Assist along with the Insurer have cross examined the records of the hospital and the Medical Director of the hospital and found that all these claims were fictitious claims and made them to accept in writing and recovered the entire amount.

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Action taken on Hospital if any: The entire amount was recovered and this hospital was removed from Medi Assist network & pop up alert is created for preventing any claims getting processed without investigation and was intimated to all other TPAs & Insurers on the same.

Case Study No.2

Name of the Hospital: "X" Hospital, AP

Type of policy : Individual

Claim Type : Reimbursement.

Claim amount : Rs 7, 60,000.00

Investigation Findings: On investigation it was found that this pt was not admitted or treated in this hospital and has disowned the documents.

Type of fraud : Fictitious admission.

Action taken on Hospital if any: Claim was repudiated and flagged for thorough scrutiny of all similar claims from this Hospital and intimated the Insurers, TPAs and Corporate..

Case Study No.3

Name of the Hospital : "X" Hospital, Bangalore
Type of policy : Group Policy.
Claim Type : Reimbursement.
Claim amount : Four claims worth approx. Rs one lakh.
Type of fraud : Converting OPD to fictitious Admissions.
Investigation Findings: Records with the hospital revealed that there was no proper documentation on all these admissions and has accepted that these patients were treated only on OPD basis.

Action taken on Hospital if any: Claims are denied and this hospital was suspended from the network immediately.

Case Study No.4

Name of the Hospital : "X" Hospital, Cuttack
Type of policy : Group Policy.
Claim Type : Reimbursement.
Claim amount : Four RI claims worthRs.237644.00
Type of fraud : Fictitious Admissions.

Investigation Findings: Confrontation with the Hospital authorities with all facts and figures revealed that these patients were neither admitted nor treated in their hospital.

Action taken on Hospital if any: Claims are denied and this hospital was suspended from the network immediately.

Case Study No.5

Name of the Hospital : "X" Hospital, Bangalore.
Type of policy : Individual.
Claim Type : Cashless.
Claim amount : Rs 25000.00
Type of fraud : Impersonation.

Investigation Findings: During the live verification of the case at the hospital, it was found that this was a case of impersonation where the actual patient was the sister of the insured who was not covered under the policy but taking treatment in place of the covered spouse.

Action taken on Hospital if any: Pre Authorization was denied and this hospital was removed from the network with immediate effect.

Case Study No.6

Name of the Hospital : “X” Hospital, Bangalore
Type of policy : Individual.
Claim Type : Reimbursement.
Claim amount : Rs 1, 50,000.00
Type of fraud : Fictitious treatment.

Investigation Findings: Our investigation reveled that the bills and cash paid receipts were generated for a future dental treatment which was not covered under the policy.

Action taken on Hospital if any: The claim was repudiated and this hospital was removed from the network immediately.

Case Study No.7

Name of the Hospital : “X” Hospital, Bangalore
Type of policy : Group.
Claim Type : Cashless.
Claim amount : Rs 45,000.00
Type of fraud : Misrepresentation.

Investigation Findings: A case of RTA recorded as self skid and fall but our investigation reveled that this patient was under the influence of alcohol at the time of RTA.

.Action taken on Hospital if any: PA denied and the concerned hospital was warned to abstain from such activities in future.

Case Study No.8

Name of the Hospital : “X” Hospital, AP
Type of policy : Group.
Claim Type : Reimbursement.
Claim amount : Rs One lakh.
Type of fraud : Fictitious admission.

Investigation Findings: Our investigation revealed that this patient was not admitted or treated to this hospital and the hospital accepted in writing that the admission documents were issued on request by the claimant.

Action taken on Hospital if any: The claim was repudiated and this hospital was blacklisted.

Case Study No.9

Name of the Hospital : “X” Hospital, Thane
Type of policy : Group.
Claim Type : Reimbursement.

Claim amount : Rs 17000.00
Type of fraud : Alteration of documents.

Investigation Findings: On our investigation it was found that this pt has paid only Rs 7000 but the bill was altered to Rs 17000 by the claimant.

Action taken on if any: The claim was repudiated.

Case Study No.10

Name of the Hospital : "X" Hospital, Bangalore.
Type of policy : Group.
Claim Type : Reimbursement.
Claim amount : 10 Reimbursement claims Rs 5 lakhs.
Type of fraud : Fictitious admissions.

Investigation Findings: On investigation it was found that all these employees were not admitted or treated in their hospital.

Action taken on Hospital if any: All claims repudiated and the hospital was Red flagged..

Case Study No.11

Name of the Hospital : "X" Hospital, AP
Type of policy : Individual
Claim Type : Reimbursement.
Claim amount : Rs 50,000.00
Type of fraud : Fictitious admission

Investigation Findings: On investigation it was found that this pt was not admitted or treated in this hospital and has disowned the documents.

.Action taken on Hospital if any: Claim was repudiated and flagged for thorough scrutiny of all claims from this Hospital.

STRATEGIC SUGESTIONS

Insurer

- **Stringent action on fraudsters like cancellation of the policy and disqualify them from availing Health Insurance benefits in future.**
- **Register criminal cases against fraudsters.**
- **Approach MCI / IMA for stringent actions on rogue medical practitioners and Hospitals.**
- **Specific exclusion of rogue Hospitals and Medical practitioners in the policy itself.**
- **Exchange data on fraud claims amongst TPAs and Insurers.**
- **Relaxation of clauses wherein with very little effort claims can be converted from exclusions to covered like admission less than 24 hrs can easily be manipulated and made to more than 24 hrs, suspected infertility treatment etc. with an extra premium.**
- **Strict measures to avoid policy issuing in the name of "non existing insured".**
- **Claim intimation to be made mandatory even for reimbursement claims.**
- **Cashless facility from preferred provider to be made mandatory to avail health insurance benefits except for emergency treatments.**

TPA

- **Strengthen investigation teams across the country in proportion to the claims flow and business allocation.**
- **Acquire claim analytics to identify fraud.**
- **Focus heavily on investigation of Reimbursement claims from fraud prone areas.**
- **Make use of the claim intimation report of RI claims effectively and investigate all suspected cases whilst the patient is undergoing treatment.**
- **To have more sophisticated gadgets for all investigators.**
- **Exchange data on fraud claims amongst TPAs and Insurers.**

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Insured: (Corporate)

- **To make attendance details mandatory from the HR team on the claim form during the admission period for all RI claims of group policies.**
- **For cashless claims by the providers, settlement advice is sent to the Insured to ascertain the genuineness of the claim.**
- **Stringent action on employees who indulge in to fraud claims and the same to be published in their intranet to set an example.**

Insured: (Retail)

- **Strict pre enrolment medical checkups.**
- **Awareness programmes to make the insured aware of the after effects of a fraud claim.**

Challenges:

- **Non co-operation of service providers.**
- **Hostile attitude of service providers.**
- **Man handling of investigators by service providers/Insured.**
- **Financial implications for investigations.**

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